



Patient Services Reporting System (PSRS)

USER MANUAL

Table of Contents

(Ctrl+click on text to go directly to sections)

Overview	1
Purpose of Patient Encounter Form (PEF)	1
PSRS – Core Legacy and GUI (Bridge):	
Security Clearance	2
Sign-On Passwords	2
Sign-On Instructions	3
Change a Current Password to a New Password Instructions	4
Sign-Off Instruction	4
Message Sending	5
Printing	5
Setting up New LHD Clinic Sites	6
PEF Entry and Other Billing Procedures:	
How to Enter Encounter Services by Document Number	6
Instructions for Completing the Encounter Entry Screen	7
PEF Retention	8
Instructions for Making Changes to the PEF	8
Patient ID Number Change Procedure	9
Merge Patient ID Numbers Procedure	9
Update Patient Master Record	9
Reason for Visit Codes.....	10
Overview of Appointment by Provider System	12
How to Set Up Provider Records	13

Inquiry for All Provider Records	13
Inquiry for Individual Provider Record – All Dates	13
How to Set Up Provider Schedule.....	13
How to Create a Schedule from Previous Schedules	14
How to Change Provider’s Schedule	15
Single Provider Inquiry	15
Multiple Provider Inquiry.....	15
Specific Inquiries by Provider	16
Scheduling Appointments	16
Next Available Appointment Inquiry	18
Day 32 Procedures.....	19
Consolidating Listing of Patient Appointments.....	19
Obtain Chart Pull Listing	20
Name Look-Up of Patients Who Are Not on Patient File	21
Missed Appointment List and Labels	21
Pap Test Results Reporting	21
Mammogram and Breast Ultrasound Results Reporting	22
CH-47 Patient Services/Supplemental Reporting	23
Supplemental Reporting Overview	23
Entering Supplemental Form	27
How to Locate the Patient by ID #	27
How to Locate the Patient by Name.....	28
How to Build/Update a Supplemental Reporting Record and Service Definitions.....	28
Procedures for Using the Supplemental System to Report Attending Group Sessions Held In the Clinic.....	32
Procedures for Reporting Community Health Services.....	32
Community Health Services Report Form Instructions (CH-48)	32
Community Based Service Activity Codes & Definitions.....	34
Community Based Service Codes	36
Billing/Payor Procedures that are Not Part of PEF Entry	37
LHD ICD-10 Cost Centers Listing	47

OVERVIEW

Kentucky Department for Public Health (DPH) contracts with Custom Data Processing, Inc. (CDP) to provide the Local Health Department (LHD) **Patient Services Reporting System (PSRS)**. **PSRS** is a computerized statewide LHD information system network existing throughout all 120 Kentucky counties and most of the LHD satellite service delivery sites offering a complete data management system for the LHDs clinical activities. *These **LHD network system** sites are connected electronically, through the creation of a statewide patient database, to each county health center and to DPH.* This database includes information needed to meet all local, state and federal government reporting requirements.

Elements of the PSRS clinic management, which the system is capable of supporting, are as follows:

- Patient encounter/services;
- Appointment scheduling;
- Breast and cervical cancer tracking and follow-up;
- Billing and accounts receivable;
- Community-based health services; and
- Facilitates patient management from outreach through continuum of care.

The PSRS **Patient Encounter Form (PEF)** is an essential part of the information system and collects the following information:

- The demographic characteristics of the patients;
- The services provided to patients;
- The LHD staff who provide the services;
- The appropriate claim information necessary for billing the patient, Kentucky Medicaid, Managed Care Organizations (MCOs), Medicare, or other third party entities; and
- The information necessary to determine WIC certifications for food instrument issuance.

A tracking system is included for certain cancer screening services. **The PSRS is linked with the LHD's financial management system and the local health personnel system.** The LHD financial management system uses the assignment of procedure/diagnosis codes which are unique to Cost Centers (*assigned by the AFM Budget Branch*) used for budgeting and costing services. An assigned provider number is the unique employee classification identification number which is consistent with the identifier used in the personnel system. The PEF is designed to fit into an online automated information systems network, but it can be utilized without a computer network.

The PEF collects data, categorizes the service information by type of visit through the use of universally accepted and AMA approved CPT (procedure) and ICD (diagnosis) codes and provides third party billing information. It is designed to relieve the health department service providers from some of the reporting burden. However, **the service provider maintains full responsibility and accountability for what is coded to the PEF.** Oftentimes, the provider simply checks or enters the CPT/HDPT procedure codes, the ICD codes and their provider number. The PSRS assigns the Cost Center and the payment source, i.e., Medicaid, MCO, Medicare, patient pay, etc.

In order to use the system for patient services, security clearances (permissions) are obtained. Only the LHD Director or their authorized designee on file with the Local Health Operations (LHO) Branch is authorized to submit a security access request to the LHO Branch for the individual's system access. All current (up-to-date) security access request forms are located on the [LHD Forms, Documents and Administrative Reference webpage](#). Only security requests forms, available on the LHD Forms, Documents and Administrative Reference webpage, are accepted by the LHO Branch.

Online inquiries and reports are available at each remote site, providing immediate access to data necessary for quality patient care and management of the clinic site.

CORE LEGACY AND GUI (BRIDGE)/PSRS SECURITY CLEARANCE

To obtain a user security access clearance, **the LHD Director or their authorized designee** must submit a signed/authorized request to the LHO Branch. The security for PSRS/Bridge is setup based only on the permissions requested using the PSRS/BRIDGE Security Request form located on the [LHD Forms, Documents and Administrative Reference webpage](#).

PSRS GUI AND CORE BRIDGE SIGN-ON PASSWORDS

An LHD employee shall not share their PSRS K Y Number (KY#). Additionally, generic accounts cannot be setup for multiple users to use or access. Each user must have their own unique user access setup within PSRS and be assigned their own PSRS KY#.

Prior to signing on the Core Bridge software, all users must sign on the Department's Local Area Networks (CHSDPHNT and CHSDPHLHD), which serves the Frankfort central office and the LHDs. Core Bridge users are required to have a unique password. Any questions regarding the Local Area Networks security, contact your local IT administrator. All non-technical questions regarding the Core Bridge software security should be directed to the LHD network security officer of the LHO Branch at 502-564-6663 Option 1, or via [email](#). All technical (system-related) questions would be directed to CDP Customer Support at (866) 237-4814 or by email at CustomerSupport@cdpehs.com.

All users are required to change their GUI and Legacy Core Bridge/ PSRS passwords **every forty-five (45) days**. A user cannot re-use the last five (5) passwords. If a user account is **inactive** for sixty (60) days, the user's account will be marked as inactive and will require a *manual reset* by the LHO Branch. For inactive user accounts, the LHD Director or Authorized Designee on file with the LHO Branch will need to [email](#) the LHO Branch. Within the email request, provide the user's assigned PSRS KY# and request the account be reactivated. This is to ensure only authorized users have access to the Legacy Bridge/PSRS system.

If any updates to the user's PSRS security access are needed the LHD Director or the authorized designee must submit a signed/authorized request to the LHO Branch. The LHD must use only the CURRENT [PSRS/Bridge Security Request Form](#).

LHDs should allow up to a minimum of two (2) business days *following* the date the correctly completed security request form [email](#) submission was received by LHO for the request to be processed. If a social security number (SSN) is needed, the LHD should fax the PSRS/Bridge

Security requests to: 502-564-4057. Type "Security" in the subject line of the fax cover page and follow instructions on the form.

Please note that email is the preferred method of security request submission unless the user's SSN is provided. LHD Director or authorized designee must sign Security Request Form when faxed. Due to HIPAA requirements, when providing a user's SSN, the LHD must submit request via fax to the LHO Branch. Mail requests are also accepted and should be forwarded to the following address:

Department for Public Health
Division of Administration and Financial Management
Local Health Operations Branch
275 East Main St., HS1W-B
Frankfort, KY 40621

ATTN: LHD Network System Security Officer

CORE BRIDGE SIGN-ON INSTRUCTIONS

- 1) With cursor in **HOME** position:
 - a. Type command: **** (hit F12 key)**
 - b. System response: **SRI PARSING STARTED.**

- 2) With cursor in **HOME** position:
 - a. Type command: **/SIGNON,KY? ? ? ?**
 - b. (Insert your assigned 4 numbers, then *hit F12 key*)
 - c. System response: **PLEASE ENTER YOUR CURRENT
PASSWORD**

- 3) With cursor in **HIGHLIGHTED PASSWORD** position:
 - a. Type YOUR PASSWORD
 - b. (Then hit F12 key)
 - c. System response: User: KY???? SIGN ON ...etc.

- 4) With cursor in **HOME** position:
 - a. Type command: **/SRI-NDL (hit F12 key)**
 - b. System response: **NDL PARSING STARTED.**

At this point sign-on is complete for Core Bridge and PC is in NORMAL OPERATION MODE.

The default password is assigned at the time PSRS access is authorized and a KY Number (KY#) is created, and anytime a PSRS password reset is requested. The LHO Branch's LHD Network Systems Security Officer will provide the default password and the assigned KY# to the LHD Director and/or LHD Director's designated authority on file with the LHO Branch. The LHD Director or designated authority will provide the user's PSRS security access credentials and default password to identified PSRS user (employee). After entering the default password at initial sign on and at each password reset the user must select a unique password.

Passwords must be five characters in length and formatted as numeric, numeric, uppercase alpha, numeric, numeric (e.g. 19A72). Do not use information that is obvious to others. Follow the [Security Standard Procedures Manual \(SSPM\)](#) outlined by the Commonwealth Office of Technology (COT) for creating passwords. Try not to use a password you cannot remember in the future. Do not write down your password and leave it accessible to other users. *All password resets, completed by the LHO Branch, to the default password, must be changed by the user from the default to an acceptable password before close of business on the date of reset or the system will lock user out, requiring another password reset by LHO.*

CORE (LEGACY) BRIDGE CHANGE A CURRENT PASSWORD TO A NEW PASSWORD INSTRUCTIONS

User must be already signed on to change their current password to a new password. Passwords must be five characters in length and formatted as numeric, numeric, alpha, numeric, numeric, e.g. 19A35. Do not use information that is obvious to others. Try not to use a password you cannot remember in the future. Do not write down your password and leave it accessible to other users.

1. With cursor in **HOME** position-
 - a. Type command: ****** (*hit F12 key*)
 - b. System response: SRI PARSING STARTED.
2. With cursor in **HOME** position-
 - a. Type command: **/NEWPASS** (*hit F12 key*)
 - b. System response: Please enter existing Password:
3. With cursor in **HIGHLIGHTED existing Password** block- type your current password.
4. Tab cursor to **HIGHLIGHTED New Password 2 Times** block- type the password you wish to use in each of the blocks (*hit HOME key then hit F12 key*).
 - a. System response: PASSWORD UPDATED
5. With cursor in **HOME** position-
 - a. Type command: **/SRI-NDL** (*hit F12 key*)
 - b. System response: NDL PARSING STARTED.

At this point password has been successfully changed and PC is in NORMAL OPERATION MODE.

CORE BRIDGE SIGN-OFF INSTRUCTIONS

1. With cursor in **HOME** position-
 - a. Type command: ****** (*hit F12 key*)
 - b. System response: SRI PARSING STARTED.
2. With cursor in **HOME** position-
 - a. Type command: **/SIGNOFF** (*hit F12 key*)
 - b. System response: User: KY???? SIGNOFF
3. With cursor in **HOME** position-
 - a. Type command: **/SRI-NDL** (*hit F12 key*)
 - b. System response: NDL PARSING STARTED.

At this point sign-off is complete for Core Bridge.

MESSAGE SENDING

The user has the ability to send message(s) and/or data screen(s) from station to station within the statewide network. The user must know the number assigned to the station where the message is to be sent. The Local Health Operations Branch staff may be reached at station # 2168 (CDM2168).

To send a message:

- a. With cursor in **HOME** position-
- b. Type command: **CDM(station#) (typed message...)** (hit F12 key)

To send a data screen:

- a. First user must remove the screen's form- hit the FRM key or CTRL key followed by the Q key-
- b. With cursor in **HOME** position-
- c. Type command: **CDM(station#) (screen...)** (hit F12 key)

Printing From Printer Queues:

The user must reactivate the printer(s) each morning to open printer queues, which allows print messages (for example: patient services reporting system: patient receipts in queue 16) to print when requested during the workday.

If printer is used for printing messages from ALL queues, key the following command:

- a. With cursor in **HOME** position-
- b. Type command: **MQP (printer#) 98** (hit F12 key)
- c. System response: Prtr # not busy queued for: 06 07 08 09 10 11 12 13 14 15 16

To open printer for particular queue(s), key the following command inserting the appropriate print queue number(s):

- a. With cursor in **HOME** position-
- b. Type command: **MQP (printer#) (print queue#)** (hit F12 key)
- c. System response: Prtr # not busy queued for: (whichever print queue)

To close all queues:

- a. With cursor in **HOME** position-
- b. Type command: **MQP (printer#) 0** (hit F12 key)
- c. System response: Prtr# not busy queued for: (nothing)

Report Printing:

Overnight processing of data entered daily into the reporting system creates numerous reports used for audit trail purposes. These daily reports are automatically sent to a designated printer and not to a particular printer queue as mentioned above.

Each morning user(s) must check to see that ALL reports created overnight were actually printed. Occasionally reports may not print as needed overnight (interference on the data line transmission or an electrical power failure might result in a partial report being printed or maybe not printed at all).

To obtain a list of all Patient Services Reporting System (PSRS) reports created overnight:

- a. With cursor in **HOME** position-
- b. Type command: **QIAI (computer site#)** (hit F12 key)
- c. System response: (List of reports, their date of creation, number of pages, etc.)

To request that a created report print:

- a. With cursor in **HOME** position-
- b. Type command: **QUPR (computer site#) (printer#) (report#) ALL**
- c. Hit F12 key **or CDS3** (Hit F12 key) and fill in appropriate data requested on the screen.
- d. System response: (Acknowledgement from system that report has been sent to the printer).

SplashBI/L-Drive/E-Reports/DataMart [Security request forms](#) are available on the [LHD Forms, Documents and Administrative Reference webpage](#)

TO SETUP A NEW LHD CLINIC SITE:

contact the LHO Branch for procedural instructions and guidelines concerning to site-naming format, Medicaid, NPI, CLIA, and Taxonomy numbers.

After receiving Medicaid/NPI/CLIA/Taxonomy numbers from payor source (e.g. Medicaid/MCO, private insurance company, Medicare) contact the LHO Branch to notify ready to complete the setup process to start billing for services at the new clinic site.

PEF ENTRY PROCEDURES AND OTHER PSRS BILLING PROCEDURES

CH-45, PATIENT ENCOUNTER FORM (PEF) and the PEF CODING SHEET are available on the [LHD Forms, Documents and Administrative Reference webpage](#)

HOW TO ENTER ENCOUNTER SERVICES BY DOCUMENT NUMBER

After the registration screen(s) have been built, services may be entered. The user must be logged onto the PEF System, and simply recall the menu. For encounter document numbers that have been created for a specified HID/LOC/Site, the user must be logged into the PEF System HID/LOC/Site specific to that site.

COMMAND: XEBARCAL<XMIT>

Enter X by PEF number, and enter the PEF number assigned for the PEF. The PEF number will be in the top right corner of the PEF Label. After you have transmitted the menu screen, the encounter entry screen will be displayed from registration.

Enter the service data now. Generally only a couple of entries will be necessary, i.e., the service code(s) and provider number. You cannot enter the next encounter through the PEF screen; you must recall the menu and enter the next document number. Another function for entering encounters is **XEBAPEF <space><PEF#><XMIT>**

If needed, subsequent encounters may be entered through this command by entering the next PEF number in the CUR field. When the PEF number is entered the next encounter will be displayed.

INSTRUCTIONS FOR COMPLETING THE ENCOUNTER ENTRY SCREEN

The Encounter Entry Screen will be brought forward filled in with information which was entered on the Registration Screen. Insurance Code, FFC, LEP, CNCT Cd and Ps/P must be completed on the Encounter Entry Screen. Instructions for completing these fields are included in the PEF instructions.

There is space for 12 CPT/HDPT codes in the top section of the screen. CPTs which do not require the ICD, units, referrals, or overrides (CPT classes 50, 60, and 70) may be entered in the bottom (overflow) section.

Additional PEF Entry Screen Fields:

At	Attending physician (Fayette County Use Only)
Se	Sec. Prov. (Fayette County Use Only)
Ap	(Enter "X") Used to tell the system to bring forward the appointment screen
Bl	(Enter "X") This item is to tell system to bring forward the bill screen when there is an exception to demand the bill screen.

If **"No Home Contact"** is indicated on the patient computer master record and the patient has a previous balance containing family planning or STD services, the bill screen will be displayed with today's charges and only non-family planning and non-STD previous balances. If the patient is alone and/or if the entire account including previous family planning or STD charges is needed, an "A" is entered in the bill screen box. All balances will be displayed and will be included on the printed bill/receipt.

Lx	Fayette County Use Only
SR	Enter "Y" if you want the Supplemental Screen returned to enter services that cannot be entered on the Encounter Form.
Cur	The Encounter number for the next PEF may be entered for encounters being entered in a batch mode from remote sites.

Once the services are entered and the screen is transmitted, if there is a patient fee, the bill screen will be displayed. The bill screen indicates the charge and any previously owed balances. If money is collected enter the amount collected for Billing Code 1 (Patient Self-Pay) in the "Bc1" field. Enter the amount collected for "other", such as Billing Code 15 (Patient Paid Co-Insurance and Deductible) in the "Other" field, and transmit the screen. The patient bill/receipt prints. Remove the receipt from printer and initial the receipt and give it to the patient. A copy of the receipt should be attached to the PEF. For Billing code 1 or Billing Code 15 payments received through the mail and payment is entered through PEF entry, a "\$" is entered in the Ps/P" field, put a "Y" in "Bl" field and transmit. On the bill screen in the "Col: Bc1" field enter the amount received (Patient Self-Pay).

If a payment is received that should apply to a Co-payment for insurance, the amount received should be entered in the "CoP" field. Transmit the screen when payment entry is complete. A receipt should be sent to the patient and a copy should be attached to the encounter document. If no money was collected, but a bill for the patient is needed, put a "Y" in the Print Bill block and transmit.

Fields displayed on the bill screen are as follows:

Vs [] Visit charge for patient
 Ag [] Agency assumed amount
 Bc1 [] Billing Code 1 – Amount patient actually owes
 Otr [] Total amount due from patient's visit for Co-Insurance (PC15)
 Prv: Bc1 [] Balance from previous visits that was Self-pay
 Otr [] Previous balance for Co-Insurance (PC15)
 Due [] Amount due for Private Pay and Co-Insurance
 Col:Bc1 [] Amount collected today for Private Pay
 Otr [] Collected today for Co-Insurance
 Don [] Today's donated amount
 Prn [] Enter X or Y if need bill printed – Enter "F" in this field when entering a service provided by an Independent Contractor following receipt of Invoice and medical record documentation. Two (2) "F" labels will be generated. Should you need more than two "F" labels, 3-9 may be entered and that number of labels will be printed.
 #Cp [] Enter # of bill copies you need printed

Insurance Billing: If 999 is entered in the INSCD field of the PEF entry screen, and total payment of the invoice is made then an insurance bill will be immediately created at PEF entry. Patient Paid Co-Insurance/Co-Payment (Billing Code 15) will be billed at this time.

Other third party billing: If 999 is entered in the (CnctC) field of the PEF entry screen; another third party bill will be immediately created.

Due to the varied nature of the services that are covered by other third parties, it is impossible to have the Patient Services Reporting System automatically determine if the services provided to a patient can be billed to another third party. When the PEF is entered for a visit that is covered, override the payor code with a "P8".

Patient Encounter Forms:

All voided [PEFs](#) **must** be retained along with the daily entry [PEFs](#) and [Supplemental forms](#). Review the KDLA [Retention Schedule](#) for LHDs.

Instructions for Making Changes to PEF

Corrections/changes that may be needed on a PEF, on the same day the PEF is entered for the first time, can be made anytime on that same day. The PEF should be opened through the "Document Inquiry" command on the Patient Encounter Entry System menu page. Corrections can be made on the PEF and then transmitted. If money for payment of services was originally entered on the document, the billing process must be completed again for the payment to post correctly to the patient's A/R.

Corrections/changes that may be needed on a PEF, on a day other than the day the PEF was first entered, must be processed through Patient Encounter History. The desired encounter should be selected from the (PERI), changes made, put "QUIT" in the "Pf" field at the bottom right of the page, then Transmit. A status message box should appear saying "Encounter History Maintenance Finished". If the LHD has multiple encounters to change, the next PEF number may be entered into the "Pf" field and then transmitted.

Corrections/changes made, on a day other than the date the PEF was first entered, do not automatically change the patient accounts/receivable (A/R) page. Most A/R changes have to be made in the patient's A/R manually. Patient A/Rs for third party billing will be available according to the specific billing cycle.

PATIENT ID NUMBER CHANGE PROCEDURE

The system will not allow the operator to change a patient's ID number when building or updating the patient's master record. Enter the following:

COMMAND:

**PCCK <Space><30><Space><LOC><Space><The Patient's Old ID#>
<Space><LOC><Space><Patient's New ID
Number><Space><CHGIT><XMIT>**

A patient ID number change should be made **PRIOR** to Registration or **any other action**. Failure to do so may result in Bridge/Portal issues with patient record.

A patient's name may be changed when building or updating a patient's master record by simply typing over the name with the correct name.

MERGE PATIENT ID NUMBERS PROCEDURE

To prevent having duplicate patient records for the same patient use the merge patient ID number if more than one patient record exists in system:

COMMAND:

**MPAT<Space><30><Space><LOC><Space><Old Patient
ID#><Space><LOC><Space><Current Patient ID
#><Space><MERGE><XMIT>**

Keeping the patient's correct ID Number in the system is critical. Periodically each health department will be sent a listing of patients who are in the system under two or more numbers. This listing is to be reviewed, and changes made to the record in the system. Special security access on user's KY Number is required for this function.

UPDATE PATIENT MASTER RECORD

At times it will be necessary when updating a patient's master record (using PSIQ) to clear a field on the screen, i.e., no home contact, patient's address, patient's phone #, etc. The following symbols must be used, as spaces remove nothing.

- The dash (-) is only used with No Home Contact
- The asterisk (*) is used to clear alpha fields

- The zero (0) is used to clear numeric fields, i.e., Income, Phone #
- The (N) is used to clear flags; Insurance
- Combination Fields that have two fields to fill in -
- Medicare [Y] Medicare # [] must first have the flag "Y" changed to "N" before system allows user to remove number # by keying *****.

REASON FOR VISIT CODES

Consistent with the DPH and LHDs' philosophy of patient centered health care, the reason for appointment/visit addresses broad categories of services; preventive medical, preventive counseling, other medical, other counseling, laboratory, radiology, etc.

With the combination of the visit type, as previously described, the provider type and the Cost Center, the reason for appointments and visits are further defined.

The code is made up of three subsets of codes. The first subset consists of two alpha characters for the visit type. The second subset is a single-digit code which identifies the provider type. The third subset is a two-digit code which identifies the Cost Center.

800 PED/AD	802 FP	803 MAT	804 WIC	805 NUTR	806 TB	807 STD	809 DIAB	810 ADULT	813 CANCER	853 HANDS	863 EPSDT	712 DENTAL
IM 200	LB202	LB303	LB304	OC405	IM306	LB107	LB309	IM210	LB113	OC353	OC483	OM172
IM300	LB302	LB503	LB504		LB306	LB207	LB509	IM310	LB213	OC953		OM372
LB300	LB502	LB903	OC304		LB506	LB307	OC309	IM910	LB313			OM572
OC400	LM202	OC303	OC404		OC306	LB507	OC409	LB310	LB513			PM172
OC900	OC302	OC403	OC904		OM106	OC307	OM209	LB510	OC313			PM572
OM100	OC402	OM103	OM204*		OM206	OC407	OM309	OC310	OC413			XR572
OM200	OM102	OM203	OM304**		OM306	OM107		OC410	OM113			
OM300	OM202	OM303	OM404**		OM906	OM207		OC910	OM213			
PC300	OM302	XR503	VP404		XR506	OM307		OM110	OM313			
PF100	PM102		VP504					OM210	PM113			
PF200	PM202		VP904					OM310	PM213			
PF300	PM302		VC304					PC310	PM313			
PM100			VC404					PF110	XR513			
PM200			VC504					PF210				
PM300			VC904					PF210				
WO800								PM110				
XR500								PM210				
								PM310				
								WO810				
								XR510				

On the following page is a matrix of logical codes for reasons for appointment and visit.

The reason for visit code is used to identify the purpose of the appointment being made. If an appointment has not been made and the patient is seen without an appointment, the reason for visit is required to be entered on the registration screen. This code is used to trigger certain flags for the appointment/registration staff, e.g., patient income information is required, health checkup is due so an appointment can be made, and proof of identity, residence and income are needed for WIC certification or re-certification. Also it is necessary to know the type of provider staff to schedule. To view a code for your site, use the following command:

PFIA<space>30<space><HIDLOC><space><APPT REASON><XMIT>

REASON FOR VISIT CODES*

NOTE: First two characters = VISIT TYPE. Third digit = PROVIDER TYPE. Fourth and fifth digits = COST CENTER

* Other Reason for Visit Codes may be assigned using the combination of the listed Visit Type – Provider Type – Cost Center. The matrix is not all inclusive.

** These codes are to be used *only* for WIC certification and re-certification visits.

VISIT TYPE

PM = Preventive Medical
IM = Immunization Visit
PC = Preventive Counseling
OM = Other Medical
OC = Other Counseling
LB = Laboratory/Pathology Services
XR = Radiology/Imaging
VP = Food Instrument (Voucher) pick-up
VC = VOC Transfer

PROVIDER TYPE

1 = Physician/Dentist
2 = APRN/CNM/PA
3 = Nurse
4 = Allied Health Provider
5 = Lab/X-ray Tech/CMA/Dental Hyg.
9 = Admins./Clinic Asst./Para-Prof.

COST CENTER

00 = Pediatrics/Adolescent	08 = KEIS	*W0800 = DCBS Lab Specimen Collection
	09 = Diabetes	
02 = Family Planning	10 = Adult Health	*W0810 = Other Lab Specimen Collection
03 = Maternity		
04 = WIC		
05 = Nutrition	13 = Breast/Cervical Cancer	
06 = TB		53 = HANDS
07 = STD		72 = Dental

EDITS

- Visit Type PM is acceptable with Cost Centers 800, 802, 810, 813 and 712.
- Visit Types OM, OC, VP, and VC are the only types acceptable in 804 WIC. WIC certifications and re-certifications should be either OM204, OM304 or OM404.
- Visit Type IM is acceptable for Cost Centers 800 and 810 only.

- Visit Types W0800 & W0810 will bypass registration items except Patient ID, Name, Birth Date, Sex and Race.

OVERVIEW OF PSRS APPOINTMENT BY PROVIDER SYSTEM

Prior to entering patient appointments by providers into the PSRS, there are several foundation files that must be created in order for the actual scheduling process to begin. The files are as follows:

Calendar Record:

The LHD calendar year is established and keyed in by CDP. The standard workdays contain all starting Monday dates for previous year, current year and next year.

Following [KRS 18A.190](#), [KRS 2.110](#) and [KRS 2.190](#), the LHD calendar also contains all the state government observed holidays, which the system will automatically blank out when setting up a providers' schedule. Until Kentucky state holiday dates are released by the [Kentucky Personnel Cabinet](#) and entered by CDP into the LHD Network Systems, it will be up to the LHDs to ensure they do not schedule during dates that are typically observed as state holidays. Therefore, by January 1 of each year, CDP will open up all calendar dates to the LHDs so scheduling can occur to avoid delays.

Once the Kentucky Personnel Cabinet determines and releases each year's state holidays, the LHO Branch will make those dates available to CDP to enter into the systems. CDP will set up and maintain this calendar record. To see the dates use the following command:

APIL<space>30<XMIT>

Provider Record:

Screen **CDS974<XMIT>** - Each provider or group of providers must be assigned a 2-digit code and set up as a separate record. The individual health department is responsible for setting up these codes.

Since the employee making the appointment must enter their employee number, it will be necessary to enter the name and 5-digit provider number of those employees making appointments to the employee file prior to their being able to enter and modify appointments. A security system has been set up for employees who are authorized to set up the provider's schedules. To obtain security access/clearance, the LHD director or his/her designee must present a signed request. All employees can make appointments.

Provider Schedule:

Screen **CDS970<XMIT>** - Each provider must be set up with a schedule for available hours per week. These provider schedules can be set up for the next 6 months.

Once the health department has started using the appointment system by provider, do not use the CDS341 screen or the ESNM function to schedule appointments.

"Appointment by provider" must be flagged YES on HID/LOC/S Maintenance screen (CDS288) by the Local Health Operations Branch staff.

HOW TO SET UP PSRS PROVIDER RECORDS

Each provider or group of providers must be assigned a code by the LHD. Codes must be numeric from 01-99. In order to schedule appointments by provider, a record must be set up for each provider/group of providers.

Screen CDS974 is used to setup and maintain the provider codes and names and the screen will appear as follows:

- Enter 30 in client field;
- Enter your HID/LOC/SITE;
- Enter the type of action as noted on the screen;
- Enter the two-digit provider code; and
- Enter the initials of the first and middle name, and entire last name.

When setting up provider codes and you would like to group providers under one provider number you may use an identifier such as nurse, RN, LPN, etc.

INQUIRY FOR ALL PSRS PROVIDER RECORDS

You should run a listing of providers/provider groups to make sure they have all been entered. The last week dates need to be watched closely and extended as needed since appointments cannot be made past this date. The system will only allow appointments to be made six months from today's date. An "*" indicates provider has been deleted. Use the following command to obtain a current list of provider records:

APIR<space>30<space><HID/LOC/SITE><XMIT>

INQUIRY FOR INDIVIDUAL PROVIDER RECORD - ALL DATES

To get a listing of valid dates for an individual provider, the following command should be entered:

APIR<space>30<space><HID/LOC/SITE><space><PROVIDER NUMBER><XMIT>

HOW TO SET UP PSRS PROVIDER SCHEDULE CDS970<XMIT>

This screen is used only once for each provider in order to complete the initial schedule of the provider.

Once the provider record is set up, you must set up a schedule for each provider/provider group for each week with the hours the provider will be available for appointments.

A schedule can be set up for Monday thru Saturday from 7:00 a.m. - 8:45 p.m. Appointment times are established on 15-minute intervals. Each dash (-) represents 15 minutes. Each provider/provider group schedule must be established by entering dashes for each 15-minute interval, which provider is not available for appointment scheduling and the number of appointments the provider/provider group can accommodate for each 15 minutes is available.

Once the schedule is entered, inquiries into the schedule may be made to see the provider schedule by week.

Instructions for completing the screen are as follows:

1. Client:
 - The client number is always 30.

- Enter HID/LOC/SITE the provider/provider group will be scheduled for the action:
 - N - New
 - C - Change
 - D - Delete
 - R - Reactivate
- 2. Provider Code:
 - Enter 2-digit provider identifier. The provider # must be on file.
- 3. Beginning Date:
 - Enter the first Monday date that the schedules will begin.
 - This date cannot be more than 6 months from today's date and must always be a Monday date.

Weeks to Repeat: Enter the 2-digit number of weeks you wish to repeat on the particular provider's schedule. The first week will count as one of the weeks and weeks should not exceed 6 months. The week(s) that the schedule will be the same can be duplicated by entering # of weeks to repeat. Do not set up for more than one week if the schedule needs to be modified.

1. # APT:
 - Enter the number of appointments, up to a maximum of nine, the provider can have for each 15-minute period.
 - If the provider is not available, enter a dash.
 - All time slots must have an entry in APT.
 - If you have a 9 in the APT column and you make 10 appointments the screen cannot show the 10 for appointments or the "X" for overbook.
 - If you do not want staff to be able to overbook, **call CDP** at (502) 695-1999 to place an "Overbook Block" on your system, which will allow only certain individuals to overbook on the schedule.
2. AREA Optional:
 - The health department must designate the area code.
 - Enter the area that the provider will be working in.
3. TYPE Optional:
 - The health department may designate the type of appointment.
 - Enter the type of appointment.
 - This may be an alpha or numeric character, i.e., W could be for WIC, P for Prenatal, S for screening, etc.
 - When transmitting, the cursor must be at the bottom of the screen.

HOW TO CREATE A SCHEDULE FROM PREVIOUS SCHEDULES IN PSRS

After the initial establishment screen, you can use the following function to fill in the schedule from another schedule. By changing the action, date, number of weeks, to repeat and making any schedule changes, you can transmit this screen and extend the schedule for an additional time period.

Enter the following:

APIP<space>30<space><HID/LOC/SITE><space><DATE><space><PROVIDER#><XMIT>

The action N is for new and will be used to extend a schedule. The action C is for change and will be used when modifying a schedule.

When extending a schedule, the beginning date must always be a Monday of a provider's schedule, if you come to a point at which you need to create additional schedules, instead of having to re-key all the data into the schedule.

When modifying a schedule, weeks to repeat can only be one week at a time. The schedule can be modified using this command; however, only a week at a time can be modified.

When using this screen to modify a schedule, make sure a listing of patients scheduled is printed out prior to modifications being made.

HOW TO CHANGE PSRS PROVIDER'S SCHEDULE

To modify or set up existing schedules for provider(s)/provider groups due to sickness, meetings, etc., the operator should call up **CDS971<XMIT>** and make the changes. Instructions for completing the screen are as follows:

1. Enter the HID/LOC/SITE
2. Enter the Action:
 - Action A is entered for Available; or
 - Action N is for Not Available.
3. Enter the providers that need to be modified.
If all Providers are to be modified, enter 999, or list all providers' numbers.
4. Enter the date(s) that the schedule will be modified.
You can enter more than one date, however, be sure to leave space between these dates.
5. Enter the military time range where modifications need to be made.

Prior to modifying a provider's existing schedule you must print out a listing of patients' schedules for the provider(s) in order to reschedule the patients' appointments. Those appointments must be voided out and re-entered after the patient has been contacted.

SINGLE PROVIDER INQUIRY

Once a Provider's schedule is set up, you can do an inquiry and view the provider's schedule for a week. A Provider's schedule may be reviewed by entering the Monday's date of the week to be reviewed. An "X" in the Remn slot means there is an overbook.

If you have a 9 in the book column and you have 10 or more patients scheduled at the same time it will only show 9 in the book column and 0 in the REMN column instead of an "X". Enter the following:

APIW<space>30<space><HID/LOC/SITE><space><DATE><space><PROVIDER#><XMIT>

MULTIPLE PROVIDER INQUIRY

You can also receive an inquiry for all providers for a specific date. The command is the same as that for a single provider except that provider number will not be entered. Enter the following:

APIW<space>30<space><HID/LOC/SITE><space><DATE><XMIT>

For multiple provider inquiries you get only the schedule for the day you have requested.

SPECIFIC INQUIRIES BY PROVIDER

The user may do an inquiry by type of visit if type has been defined in setting up the provider's schedule. For a specific Type (must be defined in Provider's Schedule) the following command is used:

**APIW<space>30<space><HID/LOC/SITE><space><DATE><space><PROVIDER>
<space><TYPE><XMIT>**

SCHEDULING APPOINTMENTS IN PSRS

Upon receiving a patient's request for a future appointment, the terminal operator will enter one of the following commands:

**APIN<space>30<space><COUNTY CODE><space><Patient ID #><XMIT>
APIN<space>30<space><COUNTY CODE><space><Patient Name><XMIT>**

If this entry results in either an exact match on patient name or patient ID, the appointment entry screen will be returned for the operator to complete.

If an exact match is not found when a patient ID number is used, a screen will return so that the patient's name can be entered. If an exact match is not found when a patient's name is used, a list of names that is at least as far along in the alphabet as the name that was keyed in will be displayed. If the correct name is listed, the operator should place the cursor to the left of the name and key in an "X". The operator should then transmit the screen, which will then result in the appointment screen being returned.

If the correct name is not listed, an "A" should be entered to the left side of the top line, which is blank, and the screen transmitted. Another screen will be returned containing appointment names not in file look-up. If the patient's name is not on the list, an "X" should be placed on the top line and the screen should be transmitted. The appointment screen will be returned for the operator to complete. All information on the Appointment Screen will transfer to the Registration Screen.

If there is more than one exact hit on the name, the following screen is returned with the patient ID number and birth date for each patient. The operator should place a "X" by the patient with the correct ID number and birth date and transmit. The appointment screen will then be displayed. The following data must be entered:

HID/LOC/SITE: The system will automatically place the HID/LOC/SITE in the appointment record. If there are multiple sites within a district, you must enter an alpha/numeric suffix for the site for new patients.

Exist Flag: If patient is on file "Y" will be filled in; "N" will appear if the patient is not on file.

Patient Identification Number:
Will be filled in for patients on file; for patients not on file, fill in with Social security number or pseudo number.

Appt -No Home Contact: Applicable only to Fayette County.

Special Elig: Applicable only to Fayette County.

Patient Name: Enter first, middle initial and last name.

Birth: Enter patient's date of birth.

WCO: WIC other (is a y/n field, if yes, it means child is getting WIC benefits from another source).

NEL: Not eligible for WIC, is a y/n field.

Address: Enter patient's address.

City, State, Zip: Enter city, state, zip code.

Phone Number: Enter patient's phone number if possible.

Book Override: This is set up by CDP and has to do with overbooking.

INIT CNT: The date that the patient was initially contacted for the WIC program.

LFUCG #: Only applicable to Fayette County.

Action: Enter action code (listed on screen).

Date: Enter appointment date.

Time: If scheduling by provider, leave blank and the provider schedule will be returned to complete scheduling.

Provider: If provider is known, enter the provider. If specific provider number is not entered, schedule screen will be returned for all providers for the specified date. If the Provider number is entered and the time is left blank, the scheduling screen will be returned for the whole week for the provider entered.

Length: If this field is left blank the system will pull length from the service file. The service file is 0 unless the LHD has called in with a specified time. If screen is blank and no time is specified on the service record, it will default to 15 minutes.

Type: If scheduling screen is returned, will only show the available times for the specified type.

Area: If scheduling screen is returned, will only show the times for the specified area.

Reason For Appointment:
First service is required for all appointments. The last three are optional. Put the service for which the patient is primarily being seen first. It is important for system accuracy that the services expected field be filled in correctly and completely. Much of the billing system depends on these codes for proper functions and editing.

Labels/Date: Will pull up address and Medical Record labels on all patients. If needed, you may also pull up appointment labels from this screen by entering the number of appointment labels needed in the label block marked "A".

Next Patient Name: Can specify the next patient ID or name to be scheduled. This can only be used if the provider scheduling screen is not pulled up.

Clerk: Enter employee ID number.

HH Screen: Enter "X" or "Y" if household screen is needed.

After you have transmitted the scheduling screen, if you did not enter the time, another scheduling screen will be returned and the appointment should be completed from that screen. If the provider's number was entered, the screen will have the provider(s) schedule for the week. If no provider was specified you will get a list of all the providers available for that particular date. If the area and/or type was entered, only those available time slots for the area/type will be shown. If the appointment is a Saturday date leave the provider number blank on this screen also and the system will then pull up Saturday's schedule.

The screen for a single provider provides the number of appointments booked, the number remaining, area and type of appointment. To schedule the appointment, put in the time. If there is not a possible time slot, blank out the appointment date and provider number and put in the alternate date and alternate provider number in the fields listed. The screen will be returned with the new week and allow you to enter the desired time and provider. If an "X" appears in the Remn appointment field that means you have overbooked. To have an overbook block placed on your appointment system, **contact CDP** at 502-695-1999 or 866-237-4814.

The multiple provider screen shows the remaining appointments and the types. Put in the provider number and time. If no time slots are available to schedule the appointment, blank out the appointment date and put another date in the alternate date field. A new screen will be returned. The label types mentioned previously may be pulled from this screen also.

NEXT AVAILABLE APPOINTMENT INQUIRY

The Appointment System has been modified so that the user can do inquiries to determine the next available appointment. This can be done for a particular provider or for all the providers at your site.

In order to do this inquiry, the user must first bring up the appointment setup screen. This can be accomplished by doing the APIN function.

The user should enter an "L" in the action field and a reason for visit. The user may also enter the date and/or the provider. The date and provider are optional.

If the user only enters the action "L" and a reason for visit, the system, starting with today's date, will search through the providers looking for available appointments. If the system locates providers that have open appointments for today, it will return a list containing all the providers who still have appointments open. If all the appointments are filled for today, the system moves on to the next available day. The system will continue this cycle until it locates a provider with open appointments.

If the user enters the action "L", a provider number and a reason for visit, the system, starting with today's date will locate the first day that appointments are available for the provider

entered. Once an open appointment has been located for the particular provider, the system will return the entire week's schedule.

If the user enters the action "L" a date and reason for visit, the system, starting with the date entered will search through the providers looking for available appointments. If the system locates providers that have open appointments for the date entered, a list containing all the providers with open appointments will be returned. If all the appointments are filled for the date entered, the system will move on to the next date. The system will continue this cycle until it locates a date with open appointments.

If the user enters the action "L", a date, provider and a reason for visit, the system, starting with the date entered, will try and locate an available appointment for the date and provider entered. Once an open appointment has been located for the particular provider, the system will return the entire week's schedule. If the system is unable to find an open appointment for the date entered, it will move on to the next day.

Due to the time involved in locating the next available appointment, the system will only maintain the next 20 available dates for a provider. However, as schedules are filled, existing schedules are updated, and new schedules are set up, these 20 dates will be updated continuously. If the user enters a date which is outside the next available date, the system will return the following message:

"DATE OUTSIDE NEXT AVAILABLE DATE RANGE".

DAY 32 PROCEDURES

The appointment system will only allow provider schedules 6 months in advance from today's date. For return visits outside this 6-month period, you can use Day 32 as a reminder. On the appointment system, enter the month and year you need to see the patient and the day will be 32. Ex. 10322000. The provider is an optional field when setting up day 32. The appointment schedule functions all work with day 32 (POIE, POIX, POIA, CDS288). The process should be set up so that at any time, a listing can be printed of all your day 32 appointments for the current month. With your listing, contact the patient and schedule a valid appointment.

CONSOLIDATED LISTING OF PATIENT APPOINTMENTS

The user has the ability to call out several different schedules at any time throughout the day. To obtain a listing of all the patients scheduled for a specific day, the following should be used:

POIE<space>30<space><HID/LOC/SITE><space><DATE><space>ALL<XMIT>

OPTIONS - A (AREA); T (TYPE); P (PROVIDER)

This report is sent to printer queue 10 and the queue must be opened in order for the report to print. To obtain a listing of all appointments within a range of time for any day enter:

POIX<space>30<space><HID/LOC/SITE><space><DATE><space><FROM TIME TO TIME><XMIT>

OPTIONS - A (AREA); T (TYPE); P (PROVIDER)

The specific Cost Center is also available and is called out through entering:

POIE<space>30<space><HID/LOC/SITE><space><DATE><space><COST CENTER><XMIT>

OPTIONS - A (AREA); T (TYPE); P (PROVIDER)

This report is sent to printer queue 10 and the queue must be opened up in order for the report to print.

To obtain a listing of appointments by individual providers, (1 provider per page) the following command should be used:

POIA<space>30<space><HID/LOC/SITE ><space><DATE><XMIT>

After this command has been transmitted operator will get the STATUS LINE MESSAGE ****Your Job will be processed shortly****; ***Job has been submitted***. The user should then call out and print Report 905 by using **CDS3<XMIT>**.

Sample reports obtained from these commands are at the back of this section.

OBTAIN CHART PULL LISTING IN PSRS

This listing is used to pull medical records of patients with scheduled appointments and to print labels. The operator may obtain up to five (5) dates of scheduled appointments at one time. Dates cannot exceed two (2) weeks from the date entered. This listing may be obtained in numeric or alpha sequence. These reports cannot be requested immediately, they are generated overnight. The operator should enter the following: **CDS288<XMIT>**

The operator should complete only the top part of the screen.

COMMAND:

Client Field - 30

Action - C

HID/LOC/SITE – your HID/LOC/SITE

Labels/Patient - Number of labels per patient, you may enter 1 - 9.

Chart # Seq - Y for listing by the medical record #, N if you want alpha listing.

Labels (1 or 2 across) - 1 for single roll of labels, 2 for 2 across labels.

Dates to Pull - dates of scheduled appointments you want to be printed.

Chart Pull Rpt Ar To Split - if you want these split out by Reporting Area.

<XMIT>

After the CDS288 screen is transmitted, the operator should review the information to ensure pull dates are correct. To review, enter the following command:

PSIL<space>30<space><HID/LOC/SITE><XMIT>

To obtain requested listing and/or labels - user must call out and print Report 300 Pull Listing and/or Report 301 Labels the next working day.

NAME LOOK-UP OF PATIENTS WHO ARE NOT ON PATIENT FILE

An inquiry may be done on a patient who has an appointment but does not have a record in the patient files. The following command should be entered.

APIO<space>30<space><COUNTY CODE><space><PATIENT NAME><XMIT>

EXAMPLE: APIO 30 500 JOHN T GIGGY<XMIT>

By placing an "X" beside the name, the patient's appointment screen will be displayed showing the appointment date, time, etc. If the patient is not on file, place an " X " on the top line, and a blank appointment screen will be displayed for you to complete.

MISSED APPOINTMENT LIST AND LABELS

Health departments may obtain a missed appointment list daily. If you wish to have this report printed at your health department, contact the CDP Customer Support Helpdesk or the LHO Branch and request that Report 865 be run for your site. You may also request Report 864, which will print labels for use in contacting these patients. The reports are run nightly for appointments missed on the previous day.

PAP and HPV TEST RESULTS REPORTING

When the CPT Codes 87624, 87625, 88141, 88142, 88143, 88164, 88165, 88174 or 88175 are entered from the PEF it will be posted to the patients encounter record and will go on the Pap/HPV Log in a pending status until the results are entered.

Once the results are received from the Lab (reviewed and coded by the nurse) the support staff will enter the results in the Results Pending Screen.

PERS<space><30><space><County Code><space><Patient ID Number><space>

<87624, 87625, 88141, 88142, 88143, 88164, 88165, 88174, 88175><space><Date Pap/HPV Test Collected><XMIT>

The Results Pending screen will come back with a space for the result code and the date the result was collected by the LHDs. Fill in the screen with the Pap result code (see code list below) and the date collected in the 6-digit format (Mo. Day, Yr.).

PAP TEST Results Category Explanation – Review [WH-58](#) form

User may need to use # before each number below depending on system programming

1. Negative for Intraepithelial lesion and negative for Intraepithelial lesion with presence of organisms or reactive cellular changes
2. Atypical squamous cells of undetermined significance (ASC-US)
3. Atypical Squamous Cells cannot rule out high grade (asc-h)
4. low grade Intraepithelial neoplasia (cin I, Mild dysplasia, HPV) (LSIL)
5. high grade Intraepithelial neoplasia (CIN II, CIN III, Moderate Severe Dysplasia, and Carcinoma In Situ) (HSIL)
6. Squamous Cell Carcinoma
7. Other – describe, includes Adenocarcinoma or Adenoma carcinoMa-In-Situ
8. Unsatisfactory
9. ABNORMAL Glandular Cells of Undetermined Significance (AGC), ATYPICAL GLANDULAR, ATYPICAL ENDOCERVICAL, ATYPICAL eNDOMETRIAL

The Results Pending screen will come back with a space for the result code and the date the result was collected by the LHDs. Fill in the screen with the HPV result code (see code list below) and the date collected in the 6-digit format (Mo., Day, Yr.).

HPV TEST Category Explanation – Review the [WH-58 Form](#)

User may need to use # before each number below depending on system programming

1. POSITIVE
2. NEGATIVE
3. UNKNOWN

Pap or HPV Tests, which are not paid for by the LHD, are to be reported on the Supplemental System. See [Supplemental Reporting System Training](#) for instructions on reporting results of these Pap or HPV tests.

MAMMOGRAM, MRI and BREAST ULTRASOUND/BI-RADS RESULTS REPORTING

Since most mammograms are provided at a location other than the LHD, the [ACH-16 Form](#) must be received before the bill is paid and the PEF entered. The ACH-16 is the result report from the radiologist. Upon receipt of the ACH-16, and after the nurse makes sure the [ACH-16](#) and the mammography report agree, the mammography results must be entered in the KWCSF Data Collection screen. When the bill is received, the mammogram service is to be recorded on the PEF and entered into the system. If the result entered in the PEF does not match the result entered in the KWCSF Data Collection screen, an error message will be displayed. In this case, verify the result with the nurse or Nurse Case Manager before making any correction of the mammogram result data on the KWCSF screen to match the result entered in the PEF.

It is imperative that the correct results are reported for the screening mammography in the KWCSF Data Collection screen and the PEF. CPT Codes 77055, 77063, 77065, 77056, 77066, 77057, 77067, G0202, G0204, G0206 and G0279 require one of the codes 0-6 be entered in the override area preceded with an "R". Or if the mammograms are contracted and paid by professional and technical component, modifier codes 26 and TC are entered in the PEF for each of these CPT codes; however, enter the codes 0-6 only for the 26 modifier, not for the TC modifier. The mammogram will get posted to the mammogram log in pending status awaiting the results.

The mammogram CPT codes listed above must have an 80000 HDPT/CPT code listed/entered first on the same PEF. The 80000 code must have a valid ICD which will tell the system the reason for the mammogram.

The Primary ICD Code to use with the 80000 Code for the CPT 77057, 77063 & 77067 and G0202 Screening Mammogram is Z12.31; the 77055, 77063, 77065, 77056 & 77066, G0204, and G0206 are to be reported with one of the billable ICD codes below:

N60.09	N62	N64.52
N60.19	N63	N64.53
N60.29	N63.	N64.59
N60.39	N64.1	N64.82
N60.49	N64.2	N64.89
N60.89	N64.3	N64.9
N60.99	N64.4	N64.52

N61	N64.51	
-----	--------	--

The one-digit result codes to be reported on the same line as the 76641, 76642, 77046, 77047, 77048, 77049, 77055, 77056, 77057, 77065, 77066 77063, 77067 and G0202, G0204, G0206 and G0279. The BI-RADS codes for mammograms and breast ultrasounds are as follows: NOTE: **Review the [WH-58 Form](#)**

- 0 Assessment Is Incomplete
- 1 Negative
- 2 Benign Finding
- 3 Probably Benign
- 4 Suspicious Abnormality
- 5 Highly Suggestive Of Malignancy
- 6 Known Biopsy-Proven Malignancy

Breast ultrasounds and MRI results reporting should follow the same instruction as listed above for mammograms; however, breast ultrasounds are not part of the [ACH-16 Form](#).

Mammograms and breast ultrasounds which are not paid for by the LHD are to be reported on the Supplemental System. See [Supplemental Reporting System overview](#) for instructions on reporting results of these mammograms. You will not have a KWCSF Data Collection Screen for these patients.

The Pap/HPV log report and the mammogram/breast ultrasound log report runs monthly. Pap/HPV log report (323) and Mammogram/Breast Ultrasound log report (676) should be reviewed monthly to assure results are listed for each patient reported through the Patient Encounter Reporting System or the Supplemental Reporting System.

If the Pap/HPV is on the 323 Report with no result; the PERS (with Pt#, CPT code, Date) screen will need to be used to enter the Pap or HPV result. If the mammogram/breast ultrasound is on the 676 Report has no result: the PERS (with Pt#, CPT code, Date) screen will need to be used to enter the mammogram/breast ultrasound result. (This is the same screen used to report Pap results.) If the mammogram/breast ultrasound is on the 676 Report as INCOMPLETE, that would be for a "0" incomplete assessment result reported.

If mammogram or breast ultrasound results are not entered in the system at the patient encounter entry; the patient encounter history screen will also need to be revised with the results. For patients that qualify for the KWCSF; the patient's cancer screen will need to be updated with result information

PSRS SUPPLEMENTAL SERVICES REPORTING OVERVIEW

The **PSRS Patient Services Supplemental Reporting System** is capable of collecting and storing patient services data, which are not reported through the [PEF](#). Such data include face-to-face encounters as well as other patient services which the health department does not provide directly or does not pay, e.g. services for Medicaid patients, those with insurance or other third party which the providing agency bills rather than the health department. There

are 100 service codes (900-999) which may be assigned and used at the discretion of the health departments.

Pediatric Outreach/Follow-up, Cancer Outreach, EPSDT Outreach have been removed from the supplemental form. However, if your health department would like to continue to count these activities, you may use the codes 900 through 999 designated for discretionary use to track these services.

This data is collected on the [CH-47, Patient Services Supplemental Reporting Form](#). It is entered and stored on a separate computer file but is linked through the patient identification number.

If a patient record created from a PEF exists on the system, the patient data will be linked with the patient identification number.

NUTRITION EDUCATION CLASSES (805):

Service Code: 36 **Definition:** Nutrition Education Class (other than WIC)

Nutrition Education may be provided in group settings other than WIC to provide a common message in a cost effective manner. The topics listed below are approved by the [Nutrition Services Branch](#) and can be provided by Nutritionist, Registered Dietitian, Certified Nutritionist, Nurse or Health Educator. Documentation must be included in the client's medical record. Class details can be obtained from the Nutrition Services Branch by calling (502) 564-3827.

Class	Target Audience	Class Information
Choose 1% or Less Curriculum	Choose 1% or Less Workgroup/ Elementary, Middle and High School	Low fat dairy choices, video, taste testing protocol, handout
Eat Smart Play Hard (ESPH)	United States Department of Agriculture/Age 3 to 12	Eat Smart Play Hard – Taste the Colors ages 3 to 4; ESPH – Snack Smart ages 5 to 7; ESPH – Power Up with Breakfast age 8 to 10; ESPH – Choose Drinks That Count! Ages 11 to 12.
Nutrition Voyage: The Quest To Be Our Best (Team Nutrition)	United States Department of Agriculture/Middle School Age	Lesson Plans for grades 7 & 8 – three lesson plans for each grade level focusing on making healthy food and physical activity choices

CANCER (When Provider Bills Medicaid or Other Third Party) (813):

The services will be documented in the Medical Record. The ONLY mammograms, breast ultrasounds, HPV tests and paps that are to be reported here are the ones who have Medicaid/Medicare or other third party (OTP) payment and the provider bills for these services. **Review the _____ Section of the Administrative Reference for Service Codes and Definitions.**

Enter the one-digit code that identifies the result of *mammogram and breast ultrasounds*

BiRads CATEGORY:	DEFINITION:
0	Assessment Incomplete
1	Negative
2	Benign Finding
3	Probably Benign
4	Suspicious Abnormality
5	Highly Suggestive Of Malignancy
6	Known Biopsy-Proven Malignancy, Technically Unsatisfactory, can't be read by a radiologist

Enter the one-digit code that identifies the result of the *pap*. User may need to use # before each number below depending on system programming

CATEGORY DEFINITION - Review the [WH-58](#) Form

1. Negative for Intraepithelial lesion and negative for Intraepithelial lesion with presence of organisms or reactive cellular changes
2. Atypical squamous cells of undetermined significance (ASC-US)
3. Atypical Squamous Cells cannot rule out high grade (asc-h)
4. Low grade Intraepithelial neoplasia (cin I, Mild dysplasia, HPV) (LSIL)
5. High grade Intraepithelial neoplasia (CIN I, CIN II, Moderate-Severe dysplasia, or carcinoma-in-sit) (HSIL)
6. Squamous Cell Carcinoma
7. OTHER-DESCRIBE, INCLUDES Adenocarcinoma or Adenoma carcinoma-In-Situ
8. Unsatisfactory
9. ABNORMAL Glandular Cells of Undetermined Significance (agc), ATYPICAL GRANDULARY, ATYPICAL ENDOCERVICAL, ATYPICAL ENDOMETRIAL

HPV result code to be entered: Review the [WH-58](#) Form

- 1 = Positive with positive genotyping (types 16 or 18)
- 2 = Positive with negative genotyping (not types 16 or 18)
- 3 = Positive with genotyping not done
- 4 = Negative
- 9 = Unknown

MEDICAID TREATMENT FUNDS (BCCTP) (813):

SERVICE CODE	DEFINITION
213	Precancerous Breast Conditions
214	Cancerous Breast Conditions
215	Precancerous Cervical Conditions
216	Cancerous Cervical Conditions

DENTAL (712):

(For information regarding these codes, contact the Oral Health Program at (502) 564-3246)

SERVICE CODE	DEFINITION
D0140	Examination by Dentist
D1211	Dentist follow-up
D1351	Dental Sealant (report referral) Units_____

LEAD TEST (When provider bills Medicaid or OTP) (800, 803, 810):

SERVICE CODE	DEFINITION
L01	Lead Test Pediatric
L02	Lead Test Maternity
L03	Lead Test Adult Health (age 16 years or older)

FLUORIDE (800):

The fluoride program is primarily for pre-school children (6 months – 6 years) who are not presently receiving fluoridated drinking water, other fluoride supplements, or vitamins with fluoride. Whether or not a child is receiving fluoride can be determined by the answers to questions on the questionnaire and consent form ([OH-9](#)).

For patients with abnormal fluoride test results from water samples submitted to the State Lab, issuing of fluoride supplements (drops or tablets) and follow-up should be followed per protocol. If the test results from the water sample are > 2.0 ppm, call the Oral Health Program Administrator at 502-564-3246 for further clarifications and directions.

FLUORIDE SUPPLEMENTS – Fluoride supplements given when patient is not in the clinic (e.g. mother picks up the supplement for child) should be reported in the supplemental system using the following codes:

SERVICE CODE	DEFINITION
S0001	Fluoride Drops 1 st dose
S0002	Fluoride Drops Refill

FLUORIDE WATER TESTING – Water samples tested for fluoride content should be reported in the supplemental system using the following code:

SERVICE CODE	DEFINITION
S0009	Fluoride Water Testing

Type of water specimen should be reported using one of the following codes:

SPECIMEN CODE	TYPE OF WATER SPECIMEN
31	Well Water (Denote well depth)
32	Cistern Water
37	Other

LHD DISCRETIONARY Codes – 900 through 999

PROVIDER and RESULT/REFERRAL/SPECIMEN:

Enter the LHD provider number of the provider who performed the service.

Enter the result codes and dates for mammograms, breast ultrasounds, pap smears, HPV tests, and Lead tests for patients that have a third party payer and have either been referred to an outside provider or the LHD have collected the specimen and sent to an outside provider.

Services such as; Cancer and Lead (patients with a third party payers) when the service is performed by an outside provider with a LHD assigned number, you may use their assigned number. If the service is performed by an outside provider without a LHD assigned number, you may use the LHD employee's assigned number who referred the patient.

Enter specimen codes for type of water tested listed under the Fluoride section.

ENTERING SUPPLEMENTAL FORM:

When entering supplemental service data, if the patient has a PEF record, the name, birth date, sex, and race fields do not need to be completed. These fields will be filled in on the screen by the computer. If a PEF record does not exist, but a supplemental record does exist, the entry screen will be filled in with patient's name, birth date, sex, and race for subsequent supplemental record entries.

Patient master records are now created in the supplemental system and these records will be interfaced with the PEF system. A patient with a supplemental record will be accessed to pull common demographic data to the PEF system.

There are five commands for computer screens for the supplemental reporting component of the system. The following pages contain instructions for using these screens.

HOW TO LOCATE THE PATIENT BY ID NUMBER:

The user must first determine if the patient has a record in the patient encounter system or the supplemental system. The patient is indexed in the system by identification number and name. The user should do an inquiry by ID # and name prior to entering data on the screen to avoid duplication.

TO LOCATE A PATIENT BY PATIENT ID # THE FOLLOWING COMMAND SHOULD BE ENTERED:

CMIP<space>30<space><LOC><space><PATIENT ID NUMBER><XMIT>

The system will search the files for patient ID #. If the ID # is found, the Services Reporting Screen will be returned to enter data. Note that certain fields will be filled in with information that was entered previously on a PEF or a Supplemental Form. Those fields must be updated with the information noted on the Supplemental Reporting Form. **Note: By updating the fields, the patient record will be updated the same as updating on the patient maintenance file.**

If the patient's ID # was not found, the system will automatically display a name look-up. The system will search for the patient's name. If the patient's name is identified, the Supplemental Reporting Screen will be displayed to enter the service.

If the patient's complete name is not identified, the system will automatically display the names in the alphabet closest to the name keyed. If the patient's name is not listed on the name look-up, place an "X" in the bracket on the blank line and transmit. The Supplemental Reporting Screen will be displayed with the HID location, ID number, and name. Complete the screen.

After completion of the screen, transmit for entry into the system.

HOW TO LOCATE THE PATIENT BY NAME:

To locate the patient by name, the following command should be entered:

CMNM<space>30<space><LOC><space><PATIENT NAME><XMIT>

The system will search the files for the patient's name and the name look-up screen will be displayed. If the patient's name is listed, the user should place an "X" before the name and transmit. If the Supplemental Reporting Screen is returned, note that certain fields will be filled in with information that was entered previously on a PEF or a Supplemental Reporting Form. Now complete and/or update the screen as necessary.

If the patient's name does not appear on the name look-up list, an "X" should be placed in the bracket by the blank line. The Supplemental Reporting Screen will be displayed with HID location and name. Complete the screen.

If the patient's name is listed **twice** on the name look-up screen, the operator will have to determine which one is the correct person. The CMNM command should be entered again using the complete name, including middle initial of the patient. Once this command is transmitted, the duplicate names showing ID number and date of birth will be displayed for you to select from.

By placing an "X" before an ID number, the system will display a Supplemental Reporting Screen for completion.

HOW TO BUILD/UPDATE A SUPPLEMENTAL REPORTING RECORD AND SERVICE DEFINITIONS

Illustration of a patient who has had a previous supplemental reporting or PEF encounter. Fields pertaining to the service must be updated.

Following are instructions for entering supplemental data on the computer screen and to print a label to be placed on the supplemental reporting form. Make sure you have queued your printer for labels.

CLIENT:	Will always be 30.
ACTN:	If entering services for the first time the system automatically places an "N" for new. On subsequent visits a "C" will appear. To delete a document, enter a "D," or to reactivate enter a "R."
HID/LOC/SITE:	The HID/LOC will be displayed on the screen. If there are multiple sites within a district, enter the alpha suffix for the site.
PATIENT ID/ MD CD#	<p>If the patient already has an ID number in the system, it will not be necessary to re-enter. If the patient's ID number is not brought forward to the screen, enter patient's identification number.</p> <p>This number is the primary means of identifying and counting patients. Accurately recording the same patient number on every visit is important. The patient's ID number is his/her Social Security or pseudo number. It is no longer the Medicaid number. For instructions on assigning pseudo numbers, see registration section.</p>

MEDICAID # If the patient's Medicaid number is not brought forward to the screen, enter the patient's Medicaid number. Patients who have applied or are potentially eligible (A) for Medicaid will not have an entry in this field until the Medicaid number is assigned. Presumptively eligible Medicaid clients will be assigned a number on the day they apply (E).

DOCUMENT #: The system will automatically assign the document number.

PLACE OF SERVICE: If service is provided at the health department, leave this block blank. Enter the one-digit alpha code for place of service. Valid places of service are as follows:

J - Inpatient Hospital
M - Patient's Home
K - Outpatient Hospital
L - Physician's Office
O - Other

Contact Date: Enter the date of the contact by entering the six-digit number in month-day-year order, i.e., 04102000.

*** If a patient record already exists in the system these items will automatically update the screen:**

1. Patient Name (L, F, M)* – Enter patient's last name. Do not use apostrophes, periods, commas, or any other special characters or symbols. Up to 17 alpha characters may be used. First name and M.I. – Enter the patient's first name and middle initial. Up to 12 alpha characters may be entered for first name, one character for middle initial. Special characters or symbols as listed above should not be used in this field.
 2. Home Phone # – Enter the area code and phone number of the patient/parent/caretaker.
 3. Name Of Parent/Caretaker (F, M, L) - (If different from patient.) Enter the last name, first name, and middle initial of the parent/caretaker. Up to 17 alpha characters may be used in last name and 12 for first name.
 4. M/Caid* – Enter (Y) if eligible; (N) no; (A) applied/potentially eligible; (M) mother; (K) K-CHIP III; or (E) Presumptively Eligible (Prenatals only).
 5. E Beg DT – Medicaid eligibility begin date.
 6. M/A Part # – Enter Managed Care Partnership number.
 7. Member # – Enter patient's member number assigned by Managed Care Partnership.
 8. AuthRef – Enter authorization number (authorized by Managed Care Partnership).
 9. Prim Health Prov – This item is designed to be used to identify the primary health care provider. Up to 9 codes are open. The Codes will be assigned at a later date.
 10. Medicare Eligible – Enter Y if eligible.
 11. Mdcr # – Enter patient's Medicare #.
- CBIS # – Enter patient's CBIS #.

12. KTAP* – Enter a (Y) yes or (N) no to indicate if benefits are/are not being received.
13. Food Stamps - Enter a (Y) yes, (N) no to indicate if the patient or family member is/is not receiving food stamps.
14. Race/Ethnicity* – Check all races as self-declared by the patient. Explain that this information is collected for reporting purposes and has no effect on any eligibility.
 - **W** (White) – A person having origins in any of the original peoples of Europe, Middle East, or North Africa.
 - **B** (Black or African American) – A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
 - **N** (American Indian or Alaska Native) – A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachments.
 - **A** (Asian) – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
 - **H** (Native Hawaiian or Other Pacific Islander) – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

His/Lat (Hispanic/Latino):

Enter "Y" (yes) or "N" (no) for the patient's self-declared ethnicity for Hispanic or Latino. Hispanic or Latino is a person of Cuban, Mexican, Puerto Rico, South or Central America, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."

15. Sex* – Enter (F) for Female or (M) Male.
16. Birth Dt* – Enter the patient's date of birth using the following format: month/day/century/year. i.e. 05051993
17. Med Rec # – For those health departments which have a numeric record system. Entry format depends on local definitions. Up to eight numeric spaces are allowed in this field.
18. Service Cd – Enter the appropriate service code.
19. Units – Some services will be reported in units. Up to 99 units are acceptable to the system.
20. Result – Enter the one-digit code that identifies the result of the pap or mammogram.
21. Provider Id # – Enter the five character provider class ID number of the health department employee providing the service.
22. Ref/Spec. Code - If a referral is made, enter the appropriate referral code from the following list. Up to 3 referral codes are allowed. For Fluoride Water Testing, the source of the water sample must be entered here. See supplemental form instructions for applicable codes.
23. Next Appt Date – Enter the next date of appointment.

24. # of Labels – Enter the number of labels to print. Place the label on the upper left corner of the form.
25. Next patient ID # –To enter data in the supplemental system for another patient, enter the patient's I.D. number and transmit.

After the information has been entered, transmit the screen. A status line message will be received indicating that the record has been built, the document number will be displayed, and a label will be printed. Place the label on the upper left-hand corner of the form. (If Fluoride Water Testing (S0009) has been reported, a water specimen label will be printed - place the label on specimen tube.)

SUPPLEMENTAL CODING NAME LOOK-UP INQUIRY:

If an encounter has been entered, the patient's name, DOB, ID #, race, and sex will be listed on the name look-up listing. This screen will display patients in alphabetical order. Remember the names on this list will only be patients who have had a previous supplemental or PEF coding encounter entered.

TO LOCATE A PATIENT ON THE NAME LOOK-UP, ENTER THE FOLLOWING COMMAND:

CMIL<space><30><LOC><space><PATIENT ID #><XMIT>

If you need to look at a document you previously entered, an "X" should be placed in the bracket by the document number and the record for that visit will be displayed. If an error has been made in keying the type of service, a change can be made. The only things you cannot change are the document number and patient ID number.

After changes are made and transmitted, you will get a status line message indicating that the document number has been changed.

LISTING OF MULTIPLE DOCUMENTS ON A PATIENT:

This inquiry will give you a listing of the documents the patient had on file by entering the following command. This list could be used to make corrections on individual documents or to assist you in verifying previous services.

CMIL<space>30<LOC><space><PATIENT ID #><XMIT>

A listing of documents will be displayed. Place an "X" in bracket before the document you would like to review.

PATIENT INQUIRY BY DOCUMENT NUMBER:

The user may call up an individual document by entering the following command:

CMID<space><30><space><HID/LOC/S><space><DOCUMENT #><XMIT>

NOTE: EACH TIME THE USER TRANSMITS THE PATIENT SERVICES/ SUPPLEMENTAL REPORTING SCREEN, A NEW DOCUMENT NUMBER WILL BE ASSIGNED BY THE SYSTEM. Therefore, DO NOT RE-TRANSMIT in the event the printer fails to print the label to your satisfaction. User must go to another page of the CRT and enter the CMID command and print the label from that screen.

If duplicate document number(s) are assigned for supplemental service(s), the user must delete the invalid number(s). To delete a document, change the action field to delete (D).

PROCEDURES FOR USING THE PSRS SUPPLEMENTAL SYSTEM TO REPORT ATTENDING GROUP SESSIONS HELD IN THE CLINIC

1. Register the patient through the regular registration process. If the only service the patient is to receive is the group education, only a supplemental form will be completed and entered into the system. A master may be built for these in the supplemental system.
2. If PEF services are also provided, register the patient as usual and print a PEF label. Record the regular service (CPTs/HCPTS) on the PEF.

Complete the supplemental form. Only the service code and provider number will be necessary for the group services provided in the clinic.

At check-out, when the PEF is entered; there will be a flag on the PEF screen to request the supplemental screen. The only data necessary to complete the supplemental screen will be the service code and provider. A supplemental label will be printed which is to be affixed to the supplemental form. **For Group Classes that LHDs wish to bill to Medicaid, a PEF must be completed and entered into the PSRS.**

PROCEDURES FOR REPORTING COMMUNITY HEALTH SERVICES

A Community Health Services Report (CHSR) CH-48 may be completed for each event/activity. The data is to be reported through the PSRS Supplemental-Community Health Services Reporting System. The data should be entered into the system within 15 days of the presentation or meeting.

Once the CHSR form has been entered into the system, a label will be produced with the key identifying information and the system assigned document number. This label should be affixed to the CHSR Form. CHSR forms should be kept on file for six years.

Up to six (6) events may be entered on the same CHSR. Therefore there may be six (6) labels affixed to the one CHSR form. If after the document(s) have been entered a change is necessary, the document number must be referenced.

A report (#615), which contains information that has been entered for each of the documents, will run the day following entry of the forms. This report will be considered your audit trail for data entry and should be kept with the input forms.

COMMUNITY HEALTH SERVICES REPORT FORM ([CH-48](#)) INSTRUCTIONS

[The Community Health Services Report \(CH-48\)](#) is to be used to report all community-based activities provided with 818 funds as well as the other Cost Centers listed on the back of the report form. The data is to be entered into the system within 15 days of the event/activity. Please note that each event/activity may be reported only once, regardless of the number of providers.

Each health department should contact the LHO Branch at (502) 564-6663, Option 1, to designate a new primary and/or secondary contact for community-based activities if they change during the fiscal year. These people are responsible for ensuring timely and accurate reporting of all community-based activities as well as assuring all health department community-based staff are aware of all communications from the state health department

pertaining to community-based activities. Problems with data entry should be forwarded to the LHO Branch at (502) 564-6663 Option 1.

County of Service Code:	Enter the county code for the county in which the event/activity took place.
Lead Provider Number:	Enter the provider number of the staff who takes the assigned lead for the event/activity.
Date of Presentation:	Entering six digits, list month, day, year the event/activity occurred.
Place/Type:	Enter the code which identifies the place the event/activity took place or the type of service as it relates to the media. These codes are located on the back of the Community Health Services Report.
Cost Center:	Enter the Cost Center for which the event is being conducted. In most cases, this is the Cost Center in which the activities were listed in your community-based activities plan.
Objective/ Program Code:	Enter the code for the 2020 objective/MCH performance measure designated in your community-based activities plan for which this activity is occurring. These objectives/performance measures should match the community-based activities plan except when the activity isn't included in the plan. In which case, choose the most appropriate 2020 objective/MCH performance measure. These codes are located as an attachment to the Community Health Services Report.
Strategy #:	Enter the two or three digit number of the strategy as designated in your community-based activities plan under the column.
Activity Code:	Enter the two digit activity code that best reflects the type of event/activity taking place (example: 01, 02, etc.).
Gender:	Enter the number of attendees that were male and the number that were female. These numbers collectively should total the same as the Total Contacts/Participants. This item should not be completed when using activity codes 4, 7, 8 or 9.
Race:	Enter the number of attendees from the respective groupings as follows: W-White; B-Black; N-American Indian or Alaska Native; A-Asian; H-Native Hawaiian or Other Pacific Islander; and U-Unknown. These numbers collectively should total the same as the Total Contacts/Participants. This item should not be completed when using activity codes 4, 7, 8, or 9. (This field does not apply to any activity for Cost Center 818 Community Objective 7.4 Local Child Fatality Review Team.)
Ethnicity:	In addition to Race, enter the total number of attendees who self-declare ethnicity for Hispanic or Latino as "L". Hispanic or Latino is a person of Cuban, Mexican, Puerto Rico, South or Central America, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino." This item should not be completed when using activity codes 4, 7, 8, or 9. (This field does not apply to any activity for Cost Center 818 Community Objective 7.4 Local Child Fatality Review Team.)
Age:	Enter the number of attendees for each appropriate age group. These numbers collectively should total the same as the Total Contacts/Participants. This item should not be completed when using activity codes 4, 7, 8 or 9. (This field does not apply to any activity for Cost Center 818 Community Objective 7.4 Local Child Fatality Review Team.)

Total Contacts/ Participants:	Enter the total number of attendees/contacts/participants.	
Contact Time:	Enter the time in minutes (15-minute increments) that was spent with the attendees in the actual event/activity.	
Prep Time:	Enter the time in minutes (15 minute increments) spent in preparing for the event. Include travel and all other time not included in contact time.	
# Cases:	Enter the number of child death cases reviewed during meeting. (This field only applies to Cost Center 818 Community Objective 7.4 Local Child Fatality Review Team).	
Agencies:	Enter the types of agencies represented at meeting. List the seven main agencies represented. If "Other" is chosen, list the type of agency "Other" represents. (This field only applies to Cost Center 818 Community Objective 7.4 Local Child Fatality Review Team).	
Causes:	Enter the cause(s) of death based on the child death cases reviewed. If "Other" is chosen, list the causes of death "Other" represents. (This field only applies to Cost Center 818 Community Objective 7.4 Local Child Fatality Review Team).	
PLACE OF SERVICE: Enter the code which identifies the place the event/activity took place or the type of service as it relates to the media. These codes are located on the back of the Community Health Services Report.		
Activity Code: Enter the two-digit activity code that best reflects the type of event/activity taking place.		
COMMUNITY BASED SERVICE ACTIVITY CODES AND DEFINITIONS		
Code	ACTIVITY	DEFINITION
01*	Health Promotion/ Education*	An interactive presentation of general information provided to community groups or other groups of people that is not required to be reported in the Supplemental Reporting System. Report each presentation separately and also report ethnicity, gender, age, and total attendance. Examples of health promotion/education included but are not limited to: nutrition education, family planning education, physical activity education, substance abuse education, and personal hygiene education.
02	Behavior Change Education	An interactive presentation provided to a group of people or individuals to teach a specific curriculum or skill and that is not required to be reported in the Supplemental Reporting System. Report each presentation separately and also report ethnicity, gender, age and total attendance. Examples of behavior change education include but are not limited to: PSI, RTR, Resource Persons Protocols, Diabetes group patient education, prenatal education, Ky. Smile Curriculum and/or demonstrations on brushing and flossing, and Safe Sitter.
03	Professional Education for Health Care Providers and Educators*	An interactive presentation provided to a group of health care providers or educators that is not required to be reported in the Supplemental Reporting System. Report each presentation separately and also report ethnicity, gender, age, and total attendance. Examples include but are not limited to: First Aid/CPR classes, Blood borne Pathogen classes, Diabetes Awareness sessions, and Smoking Cessation classes.

04*	Information and Material Distribution*	A non-interactive activity involving the distribution of educational materials or information that is not required to be reported in the Supplemental Reporting System. Report each activity separately, but do not report ethnicity, gender, age, or total participants. Examples of non-interactive activities include but are not limited to: distribution of brochures, newspaper articles, informational hotlines, and television or radio educational programs.
07	Community Planning Activities*	Intended to measure activities in which staff are involved with the community working toward a common goal of improved health for its citizens. Examples of community planning activities include but are not limited to assessing the community's health problems, serving on community groups/coalitions, and activities related to APEX-PH, PATCH, and the transition model. Report each activity separately, but do not report ethnicity, gender, age or total participants.
08	Other Activities	This activity code is to be used only as a last resort for activities that will not fit into one of the categories defined above.
09*	Health Fair*	Interactive, non-interactive, general, and specific topic presentations to community groups or other groups of people in a health fair setting that is not required to be reported in the Supplemental Reporting System. Report each presentation separately but do not report ethnicity, gender, age and total attendance. <i>Examples of health fairs include:</i> an unmanned booth at the grocery store on the importance of eating five fruits and vegetables per day or a booth at a work site with material on the importance of monthly breast self-exams.

TO ENTER NEW DOCUMENTS

COMMAND:

COID<Space><HID (your HID# here)><Space><N><XMIT>

A Community Health Services Reporting label is printed automatically when document is entered and is to be affixed to [CH-48 form](#).

TO RETRIEVE ENTERED DOCUMENT FOR CHANGING/DELETING

COMMAND:

COID<Space><HID (your HID# here)><Space><Doc#><XMIT>

A Community Health Services Reporting label is printed automatically when document is entered and is to be affixed to [CH-48 form](#).

TO CHANGE DOCUMENT: Make changes on screen then xmit screen.

TO DELETE DOCUMENT: Change Act [] from 'C' to 'D' then xmit screen, system will print a "deleted" document label.

Action Codes: **N** - for new record
 C - for change to existing record
 D - to delete an existing record

COMMUNITY BASED SERVICE CODES:

PLACE/TYPE OF SERVICE CODES		COST CENTERS			
01	School	*Note: The Cost Center number input <u>must correspond</u> with the Cost Center number the activity falls under in Community-Based Plans, if included in plan. If activity was not included in plan, choose the most appropriate Cost Center.			
02	Worksite				
03	Health Department				
04	Community (general)	722	Asthma Education	832	Heart Disease or Stroke
05	Other Agency/Institution	735	COPD	833	Breastfeeding Regional Coordinator
08	Newspaper/Newsletter	736	Healthy Communities		
09	Radio	801	Immunizations	856	Arthritis or Osteoporosis
10	Television	843	HIV	857	Physical Activity
11	Website	805	Nutrition		
12	Other Media	806	TB	890	Core Community Assessment
13	Billboard	807	STD		
		813	Breast and Cervical Cancer	<div>* Review the Financial Management Section of the Administrative Reference for additional information on Cost Centers</div>	
		818	Community		

2010 OBJECTIVES/PROGRAM CODES

***Note:** When reporting activities, 2010 Objectives/Program Codes should match the ones used in the Community-Based Plans.

ACTIVITY CODES

- 01 Health Promotion/Education
- 02 Behavioral Change Education
- 03 Professional Education for Health Care Providers and Educators)
- 04 **Information & Material Distribution**
- 07 Community Planning Activities
- 08 Other Activities
- 09 Health Fair

AGENCIES

- 1 Coroner
- 2 Law Enforcement
- 3 Department for Community Based Services
- 4 Local Health Department
- 5 Attorney
- 6 Emergency Medical Service
- 7 Fire
- 8 Other

CAUSES

- 1 SIDS
- 2 Illness or Other Natural Cause
- 3 Drowning
- 4 Vehicular
- 5 Suffocation/Strangulation
- 6 Fire/Burn
- 7 Undetermined
- 8 Prematurity
- 9 Falls
- 10 Poison/Overdose
- 11 Homicide
- 12 Suicide
- 13 Other

BILLING/PAYOR PROCEDURES THAT ARE NOT PART OF PEF ENTRY

PATIENT SELF-PAY (BILLING CODE #1)

Monthly statements for patient pay account balances are generated on the 597 E-report. The 597 runs the first weekend following the end of the month. E-report 598 contains statement labels. These statements are made available to LHDs to utilize in billing patients for outstanding self-pay invoices. Receipts for any self-pay payments received should be provided to the patients.

QUPR<space><SITE #><space><PRINTER #><space>3<space>ALL<XMIT>.

Payments received in the mail for amounts owed by patients may be entered using the following procedures.

1. Set up a cash target amount for the batch total dollar amount that you will be entering at one time. Use command **CDS304<XMIT>**.
2. You may review a patient's account with the command:

PARI<space>30<space><LOCATION><space><PAT ID><XMIT>

3. Use the entry of cash receipts screen (CDS302) to enter each patient's payment as:

S<space><PAYMENT><space>P<space><PAT ID><XMIT>

MEDICAID BILLING/MEDICAID MCO's (BILLING CODES #2, 23, 24, 25, 26, 27, 28, and 29)

To Setup a New LHD Clinic Site: Review the LHO Section of the Administrative Reference or contact the LHO Branch for procedural instructions and guidelines.

For LHDs that participate in the Kentucky Preventive Health Services Program, the PSRS will automatically bill for covered services for patients enrolled in traditional Kentucky Medicaid or a Medicaid MCO.

Each of the service providers for your department has a third party billing status "flag" (Yes) or (No) in their provider master record. This flag is used to determine if any third parties may be billed for each provider's services to a covered patient. All employees are automatically flagged yes. Independent contractors are individually flagged based upon the information in their contract and entered at the state level.

We recommend that a Kentucky Medicaid Preventive Health Services Program Statement of Authorization – Other Providers form be obtained for each independent contractor and other provider used by your department.

At the end of each month, the Applied Potential Medicaid report #375 is available. The report lists all patients (and their PEFs with covered services) who were marked as applied potentially eligible for Medicaid/Medicaid MCO. PEFs containing WIC only services will not be listed. When the patient receives their Medicaid/Medicaid MCO card, use the following procedures to bill for those service dates that were covered:

Retro-Active Billing:

1. The retro-active screen for each patient is brought up using the command:

NERI<space>30<space><LOCATION><space><PATIENT ID#><XMIT>

2. In the first column on the screen enter the correct code on the same line as the PEF you want to bill to Medicaid/Medicaid MCO or on which you want to change the billing status. Allowable codes are:

Enter "Y" or "X" to flag Medicaid eligible. Covered services provided by billable providers will be added to the next Medicaid/Medicaid MCO billing.

Enter "N" to flag patient not eligible for Medicaid on the date of the service. The PEF will no longer appear on the 375 report at the end of the month. If a self-pay charge results, the A/R amount will automatically be set up.

Enter "A" to re-flag Medicaid applied or potentially eligible. (Use for corrections.)

If the patient has coverage through a Medicaid Managed Care Partnership, enter the region number in the Par # field. Transmit to change the billing status. The converting to Medicaid audit trail will be produced under print Queue 9.

REMEMBER: WIC only PEFs will not be listed and PEFs will no longer appear on the 375 report anytime the status is changed from an A, P, or M.

When corrections are made to PEFs in the history file, covered services on those corrected PEFs will automatically bill to Medicaid or Medicaid Managed Care provided that none of those services were previously billed.

If your department needs to make mass changes to your Medicaid or Medicaid Managed Care billings due to a change in the billing status of an independent contractor or other provider or due to a retro-active addition of a site to the Preventive program, contact the [LHO Branch](#) for specific instructions.

If a claim has already been billed and requires corrections, that claim must be resubmitted by using the CPOD function. A separate electronic billing will be created. First, correct any and all errors in the PEF history file or patient master record that caused a denied claim. Also correct the patient's accounts receivable for Medicaid/Medicaid MCO using the following procedures:

1. Set up a cash target amount of \$0 since no cash will be involved in this type of patient accounts receivable transaction. Use command **CDS304<XMIT>**.
2. You may review a patient's account with the command:

PARI<space>30<space><LOCATION><space><PAT ID><XMIT>

3. Use the entry of cash receipts screen (CDS302) to enter each patient's account receivable adjustments. Adjustments will include reducing the A/R for any services that were denied payment and cannot be re-billed or changes in the A/R amount for services that were denied payment and must be re-billed at a different rate. Any services that are being billed that were not billed electronically must have an amount set up in the patient's A/R.

Electronic Re-billing:

The following computer procedure is available to produce the electronic re-billing:

The electronic re-billing screen is brought up using the command:

CPOD<space>30<space><LOC><space><PEF#><space>2<space>2<XMIT>

Use:

CPOD<space>30<space><LOC><space><PEF#><space>9<space>2<XMIT>

for Insurance TPL Medicaid billing. The rebilling screens may also be accessed via the Billing tab drop down box.

Review the information on the screen. Delete any services and associated information that have already been paid by Medicaid from a previous computer billing. For Insurance TPL billing, enter the amount paid by the insurance company in the insurance paid field.

Enter the invoice # in that field. If you are re-billing a denied claim, a number was already created by the computer for the first billing, use that number. If this is the first billing for a service that requires written documentation, or for Insurance TPL billing, use the invoice # that was used to create the patient account receivable.

1. When resubmitting a claim, enter the appropriate bill frequency code in the Medicaid Resubmission Code field.

#7 = **Replacement** of prior claim

#8 = **Void/Cancel** of prior claim

2. Remember to enter the ICN of the claim being adjusted in the Original Ref. No field.

HCFA - 1500 MEDICAID SCREEN

Patient's Name (L,F,M) DOE JOHN Insured's I.D. Number 001111111 Family Planning N

Diagnosis Codes V069 Provider C3564 Invoice #

Encounter Date 01/22/2013

Cpt/Modif	Units	Dia	Ref	Disp	Charges
90723	1	1			18.40
90670	1	1			18.40

Total Charge: 73.60

Medicaid Resubmission Code 7
7=Replacement of prior claim
8=Void/cancel of prior claim

Original Ref. No. ICN OF CLAIM ADJUSTING

Print HCFA? N

Use the command:

MQP<space><PRINTER#><space>2<XMIT>

to release the print Queue and print the bills.

Please remember that the above procedures only create an electronic billing entry or print a bill. No changes are made to the Patient's account receivable or the PEF history file by these procedures. Those changes have to be made separately.

The following procedure offers the ability to rebill multiple claims to a different payer if initially billed incorrectly:

NERB><client><LOC><Patient ID>

This function can be used for these payers: (M) Medicaid/MCO, (I) Insurance, or (B) Medicare Part B. If no errors are returned on the Audit Trail, the system will automatically update the registrations and create the A/R invoice for the dates of service selected. The electronic claim will be on the next billing cycle. Paper claims will be sent to Que#2. The Audit Trail is sent to Que #9.

New CMS 1500 Screens

This function gives full functional control over the CMS 1500. The screen may also be accessed through the PERI screen.

CPCC><30 ><HLS><PEF#><TYPE><PAY CD>

Type 2-Medicaid/MCO

Type 3-Medicare

Type 9-Insurance

When a new CMS1500 screen is created the information from the Patient Encounter Form will be used to populate the screen.

CPCH Function allows changes to an existing CMS1500 record.

The following will direct you [to CDP User Training documents](#). Contact CDP should you have questions to or difficulty accessing these documents.

For Kentucky Medicaid MCO billing-related claim errors or problems, the LHD should initiate the first contact [to the MCO](#) in order to resolve the issue. In the event the MCO cannot sufficiently provide resolution to the issue, an LHD Billing Specialist may contact the LHO Branch to seek guidance and/or support in obtaining resolution.

MEDICARE BILLING (BILLING CODE #3)

Some physician services, on-site laboratory services and Influenza and Pneumonia injections may be billed to the Medicare Physicians Services program. See the [Medicare Preventive Services Guide](#) for specific information.

Also available is a special program for billing only immunization services including influenza and pneumonia. If your department is enrolled in either program, Medicare services are automatically billed at the state level on a weekly basis.

[CONTACT THE LHO BRANCH FOR PROCEDURES AND GUIDELINES NEEDED TO SETUP A NEW LHD CLINIC SITE](#). Specific information for each clinic site and for physician or mid-level providers, including NPI and UPIN#, must be in the master files in the system.

Contact the [LHO Branch](#) for guidance on the procedures in submitting the required NPI and UPIN numbers to have them entered in to the PSRS master files. However, keep in mind that DPH is not a Medicare provider and therefore, due to HIPAA requirements, the LHO Branch does not answer Medicare billing related issues and cannot contact Medicare on behalf of an LHD to assist with billing errors, inquiries or concerns. The LHD must resolve billing issues directly with Medicare.

Corrections to individual PEFs in the history file will enable covered services on the corrected PEF to be automatically billed to Medicare if any of the services on the PEF have not previously been electronically billed to Medicare.

Denied Medicare claims re-billings must be submitted to the Medicare carrier by using the CPOD function. A separate electronic billing will be created for these claims. First, correct any errors in the PEF history file or patient master record that caused a denied claim. Also correct the patients' account receivables for Medicare using the following procedures:

1. Set up a cash target amount of \$0 since no cash will be involved in the type of patient accounts receivable transaction. Use command **CDS304<XMIT>**.
2. You may review a patient's account with the command:
PARI<space>30<space><LOCATION><space><PAT ID><XMIT>
3. Use the entry of cash receipts screen (CDS302) to enter each patient's accounts receivable adjustments. Adjustment will include reducing the A/R for any services that were denied payment and cannot be re-billed or changes in the A/R amount for services that were denied payment and must be re-billed at a different rate. Any services that are being re-billed that were not billed electronically must have an amount set up in the patient's A/R.

The following computer procedure is available to produce the electronic re-billings:

1. The electronic re-billing screen is brought up using the command:
CPOD<space>30<space><LOC><space><PEF><space>3<space>3<XMIT>
2. Review the information on the screen. Delete any services and associated information that have already been paid by Medicare from a previous computer billing.
3. Enter the invoice # in that field. If you are re-billing a denied claim, a number was already created by the computer for the first billing so just use that number. If this is the first billing for a service, use the invoice # that was used to create the patient's account receivable.
4. Transmit the screen to create an electronic billing entry.

Please remember that the above procedure only creates an electronic billing entry. No changes are made to the Patient's account receivable or the PEF history file by this procedure. Those changes will have been made separately.

OTHER THIRD PARTY BILLING (BILLING CODE #8)

The billing procedures for other third parties are similar to those available for the insurance company automated billing procedures. Other third party billings are automatically prepared at the state level on a monthly basis using information from the Patient Services Reporting System (PSRS). Since we currently lack sufficient volume to any one third-party to bill them

electronically, use report 736 Invoice Register as a billing document for these payors. DPH is not a private/commercial insurance provider and therefore, due to HIPAA and other third-party requirements, the LHO Branch does not provide assistance on behalf of an LHD to assist with resolution of billing errors, inquiries or concerns. The LHD must resolve billing-related issues directly with their contracted third-party (private/commercial) insurance company/agency.

LHDs will assign Contract Codes in the PSRS/Bridge and CMS-Portal systems (instructions below). To see a list of Contract Codes in PSRS/Bridge for your HID/LOC, use LXID 30 HID. Patient encounter forms (PEF) will be used to report all billing code #8 services. On PEF entry the Contract Code shall be entered in the designated field (CnctC) and P8 shall be entered in the override field (Ovr:Da) for each CPT.

On the CDS351 screen, the ONLY fields that have to be completed for Payor Code 8 setup are:

- Client: always 30
- Act: (N)ew, (C)hange, (D)elete
- Contract Payor (I/9-C/8): C
- Hid: your LHD Hid
- Code: the Contract Code your agency is assigning to this agreement
- Payor Source: name of Contractor
- Company Name: (may be the same as Payor Source)
- Address, City/State/Zip, Phone Number

Additional information can be found in the AR [Financial Management Section](#).

Invoices will be setup automatically the first weekend of following month by CDP. Report 736 will contain all P8 services reported in the previous month separated by Contract Code.

To print the monthly CMS 1500 bills that are to be sent to other third parties, use the following procedures:

1. The monthly bills should be ready to print after the first weekend of each month.
2. All bills to all other third parties are printed in order on continuous CMS 1500 forms. Use the command:

QUPR<space><SITE#><space><PRINTER#><space>765<space>ALL<XMIT>

to release the print queue and print the bills.

Denied other third party claims re-billings must be submitted to the other third party via another paper CMS 1500 form. Correct any errors in the PEF history file or patient master record that caused a denied claim. Also correct the patients' account receivables for other third party.

The following computer procedure is available to print the CMS 1500 form as part of the re-billing process:

1. The on-demand CMS 1500 billing screen is brought up using the command:
CPOD<space>30<space><LOC><space><PEF#><space>8<space> 8<XMIT>

2. Review the information on the screen. Delete any services and associated information that have already been paid by other third parties from a previous computer billing.
3. Enter the invoice # in that field. If you are re-billing a denied claim, a number was already created by the computer for the first billing, so just use that number. If this is the first billing for a service, use the invoice # that was used to create the patient's account receivable.
4. Transmit the screen to create a CMS 1500 under print queue #2. At the end of an on-demand CMS 1500 bill creation session, all bills to all payors are printed in order on continuous CMS 1500 forms. Use the command:
MQP<space><PRINTER #><space>2<XMIT>

to release the print queue and print the bills.

Please remember that the above procedure only prints a bill. No changes are made to the patient's account receivable or the PEF history file by this procedure. Those changes have to be made separately.

Payments received for amounts owed by other third parties may be entered using the following procedures:

1. Set up a cash target amount for the batch total dollar amount that you will be entering at one time. Use command CDS304.
2. You may review a patient's account with the command:

PARI<space>30<space><LOCATION><space><PAT ID><XMIT>

3. Use the entry of cash receipts screen (CDS302) to enter each patient's payment as:

I<space><PAYMENT><space>P<space><PAT ID><space><INV#><XMIT>

INSURANCE BILLING (BILLING CODE #9)

CONTACT THE LHO BRANCH FOR PROCEDURAL INSTRUCTIONS AND GUIDELINES WHEN NEEDING TO SETUP A NEW LHD CLINIC SITE.

The billing procedures for insurance companies are similar to those available for the Medicare automated billing procedures. Insurance billings are automatically prepared at the state level on a bi-monthly basis using information from the Patient Services Reporting System.

Medicare rules are used to determine if a service should be billed to an insurance company. If you want services in addition to those that would be included, using the Medicare rules to be included in your insurance billings, [contact the LHO Branch](#) to determine what updates are needed, if any, within the system.

DPH is not a commercial/private insurance provider and therefore, due to HIPAA requirements, the LHO Branch cannot contact a commercial/private insurance company on behalf of an LHD to assist with billing errors, inquiries or concerns. The LHD must resolve billing issues directly with the insurance company.

The following computer procedure is available to print the CMS 1500 as part of the re-billing process: Correct any errors in the PEF history file or patient master record that caused a denied claim. Also correct the patients' account receivables for insurance.

1. The on-demand CMS 1500 billing screen is brought up using the command:

CPOD<space>30<space><LOC><space><PEF#><space>9<space> 9<XMIT>

2. Review the information on the screen. Delete any services and associated information that have already been paid by insurance from a previous computer billing.
3. Enter the invoice # in that field. If you are rebilling a denied claim, a number was already created by the computer for the first billing, so just use that number. If this is the first billing for a service, use the invoice # that was used to create the patient's account receivable.
4. Transmit the screen to create a CMS 1500 under print queue #2. At the end of an on-demand CMS 1500 bill creation session, all bills to all payors are printed in order on continuous CMS 1500 forms. Use the command:

MQP <space><PRINTER#><space>2<XMIT>

to release the print queue and print the bills.

Please remember that the above procedure only prints a bill. No changes are made to the patient's account receivable or the PEF history file by this procedure. Those changes have to be made separately.

Payments received for amounts owed by insurance companies may be entered using the following procedures:

1. Set up a cash target amount for the batch total dollar amount that you will be entering at one time. Use command **CDS304<XMIT>**.
2. You may review a patient's account with the command:

PARI<space>30<space><LOCATION><space><PAT ID><XMIT>

3. Use the entry of cash receipts screen (CDS302) to enter each patient's payment as:

I<space><PAYMENT><space>P<space><PAT ID><space><INV#><XMIT>

INSURANCE AND CONTRACT PAYOR/BILLING CODES IN THE CMS-PORTAL SYSTEM AND THE BRIDGE SYSTEM

*Insurance 9 and Contract/Billing Code 8 need to be built in **both** Bridge and the CMS system. Changes to Insurance or Contract/Billing Code 8 need to be changed in **both** Bridge and the CMS system.*

TO BUILD AN INSURANCE OR CONTRACT IDENTIFICATION CODE FOR BILLING IN THE BRIDGE SYSTEM (CDS351)

Insurance or Contract Payor (I/9-C/8) – Enter billing Code 9 for an insurance company or Billing Code 8 for any other contract payor.

Code – Enter the code 001 to 8999 of the insurance company or other payor that you are building. You may use up to 8999 codes for insurance companies/policies and up to 8999 for

other payors. For Contract/Billing Code 8, enter the contract number that your department assigned to the contract when it was written

Lex Contract Code and Contract Number – Enter the contract number that your department assigned to the contract when it was written. (ONLY for Lexington-Fayette County)

Co-Pay – Enter P if there is a known percentage co-pay/per visit associated with the insurance company or policy of the insurance company. Enter F if the co-pay is a flat rate per visit. (For Insurance/9)

Co-Pay Percentage – If the co-pay is a percentage of total charges, enter the percentage. (For Insurance/9)

Flat Rate – If the co-pay is a flat rate per visit (with communicable disease is primary reason), enter the amount. (For Insurance/9)

Company Name – Enter the Insurance Company or other third party payor name in this field. Also complete the remainder of the fields for the address. (Payor Source may be the same as Company Name)

Complete the fields for “Nurse bill” if your registered nurses can bill the insurance plan and “NEIC” for them is a number available for electronic insurance billing. A listing may be found at [CDP’s website](#). Look for “Capario Payer List – Insurance Company numbers”.

When setting up Contract/Billing Code 8, ONLY the fields in the red in the Bridge CDS351 screen below need to be completed.

Insurance/Contract Mice

File Edit Patient Billing Lab Table Follow-up Supplemental Community Navigate Printing Help

CDS0351 INSURANCE AND CONTRACT PAYOR CODES

Insurance or

Client	Act	Contract	Payor (I/9-C/8)	Hid	Code

Lex Contract Code: Contract Number:

Donated Services: Fee Book Flag:

Co-Pay: Co-Pay Percentage: Flat Rate:

Payor Source: Company Name: Address: Address2: Address3: City/St/Zip: Phone Number: () -

Anthem-BC/BS flag Bill Nurse Visits

Bill Electronically? NEIC Payor

Transmit

5/19/20 2:30 PM Page

PATIENT ACCOUNTS RECEIVABLE CREATION AND ADJUSTMENTS

Individual patient's account receivables (A/R) are automatically created by the computer system for patient, Medicaid, Medicaid MCO's, Medicare, insurance, other third party.

1. The patient pay account receivable is created immediately upon entry of the PEF into the system. Immediate corrections to the PEF on the day of entry will also immediately correct the patient pay A/R. After the overnight posting process, corrections to the A/R must be done through screen 302 transaction procedures.
2. Medicaid, Medicaid MCO's, Medicare, insurance and other third party and A/Rs for each patient are automatically created as part of the automated billing procedures for these payors.
3. Adjustment of patient's account due to errors or due to the write off of bad debts is made using the screen 302 transaction procedures. Please consult your internal control procedures for write off rules.

PSRS AND ELECTRONIC POSTING OF PAYMENTS

Payments from the Medicaid Preventive Health Program and Medicare Physicians Program can be automatically posted to the patient's account through PSRS. Electronic remittances from those payors are used to make the payment entries. Please consult with EACH Payor for their Electronic Data Interchange (EDI) instructions.

Errors in the electronic posting process are listed on report 580 (Medicaid), 119 (Medicare), 120 (Rail Road Medicare), and 2580 (Lead Medicaid). Use the Patient A/R correction procedures and screens 304 and 302 to correct the errors. It is the LHD's responsibility to review these reports and ensure any errors are corrected.

LOCAL HEALTH DEPARTMENT - ICD-10 COST CENTERS LISTING

For specific LHD Cost Center information, refer to the Administrative Reference (AR), [Financial Management Section](#).

The **LHD ICD-10 COST CENTERS LISTING** is reviewed annually. Needed updates are made according to the changes from the American Medical Association (AMA) on the ICD10 code set.

The [Local Health Operations \(LHO\) Branch webpage](#) contains an [ICD-10 Cost Center Listing](#).